

Prior Authorization

[Refer to WAC 388-531-0200]

Limitation Extensions and Expedited Prior Authorization numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services. For example: Therapies are not covered under the Family Planning Only Program.

MAA's prior authorization requirements are met through the following authorization processes:

- Written or fax authorization; and
- Expedited prior authorization (EPA).

These authorization procedures do not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care. [Refer to WAC 388-502-0120]

Limitation Extensions (LE)

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administrative Code (WAC).

How do I get LE authorization?

Some LE authorizations may be obtained by using the Expedited Prior Authorization process. Refer to the EPA section (page I.5) for criteria. If the EPA process is not applicable, limitation extensions may be obtained using the written/fax authorization process (see below).

Written/Fax Prior Authorization

What is written/fax prior authorization?

Written or fax prior authorization is a paper authorization process available to providers when expedited prior authorization has not been established or the expedited prior authorization criteria is not applicable.

Which services require written/fax prior authorization?

All services noted in WAC, MAA's billing instructions, and/or the fee schedule as needing prior authorization (PA), require written or fax prior authorization.

EXAMPLES of services that require written/fax prior authorizations are:

Code	Procedure
54416-54417	Repair of Penile Implant
55873	Cryosurgical Ablation of the Prostate
61885, 61886, 64573 and 64585	Vagus Nerve Stimulator Insertion, Removal, or Revision
66930 and A9900	Cochlear Implantation and External Replacement Parts
67909	Reduction of Overcorrection of Ptosis
69714-69718	Osseointegrated Implants
78810	Tumor imaging (PET)
88380	Microdissection
95965-95967	Magnetoencephalography (MEG)
99221-99223	Inpatient Acute PM&R
G0030-G0047	Myocardial perfusion imaging (PET)
J2020	Linezolid injection
J2940	Somatrem injection
J2941	Somatropin injection
J7340	Metabolic active D/E tissue
S0093	Morphine 500 mg
0009T-0013T	New technology CPT Category III codes

How do I obtain written/fax prior authorization?

Send or fax your request to:

MAA – Division of Medical Management
 Attn: Medical Request Coordinator
 PO Box 45506
 Olympia, WA 98504-5506
 FAX: (360) 586-1471

On the following pages are sample fax forms for your convenience. All the information on the form is required by MAA.

Fax/Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# _____ - - -
i.e. (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

Procedure Code _____ Number units requested _____ number units used this year _____

Medical Information

Dates of injury or illness _____

Diagnosis code _____ Diagnosis name _____

Place of service _____

How will approving this request change the course of treatment?

Goal of treatment? _____

What is the clinical justification for this request (if not addressed above?)

Please send in any necessary additional documentation with your request to:

Fax: **360-586-1471**

or mail to: Medical Request Coordinator
MAA/DMM
PO Box 45506
Olympia, WA 98504-5506

PET SCAN INFORMATION FORM

Medical Assistance Administration

Telephone: (360) 725-1584

FAX: (360) 586-1471

PATIENT NAME: _____

BIRTHDATE: _____ PIC CODE: _____

ICD 9 CODE (with DIAGNOSIS):

1) _____ (Diagnosis): _____

2) _____ (Diagnosis): _____

3) _____ (Diagnosis): _____

DOES MEDICARE COVER PET SCAN FOR THIS DIAGNOSIS? _____

INDICATIONS FOR PET SCAN: _____

SENSITIVITY AND SPECIFICITY OF PET SCAN IN THIS SETTING: _____

INDICATIONS WHY OTHER IMAGING WILL NOT WORK: _____

OTHER STUDIES/TESTS ALREADY DONE and RESULTS: _____

HOW WILL PET SCAN RESULTS CHANGE THE COURSE OF TREATMENT? _____

PROVIDER'S MEDICAID NUMBER (7 DIGITS): _____

FACILITY NAME: _____

DOCTOR' NAME _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

ADDRESS: _____

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care.

What is the EPA process?

MAA's EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

How is an EPA number created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* section when billing electronically.

Example: The 9-digit authorization number for a brain MRI in a client with suspected brain tumor and new onset of unexplained seizures would be **870000303** (**870000** = first six digits of all expedited prior authorization numbers, **303** = last three digits of an EPA number and specific diagnostic condition, procedure, or service, and which criteria the case meets).



Note: Prior authorization is required when the client's situation does not meet published criteria and there is no option to create an EPA number that indicates medical necessity is documented in the client's medical record.

The service is not covered if there is an option to create an EPA number based on the medical necessity being documented in the medical record and medical necessity cannot be documented.

Expedited Prior Authorization Guidelines

- **Diagnoses**

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number is denied.

- **Documentation**

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request. When care is received in the hospital, the documentation of how the expedited prior authorization criteria were met must also be in the hospital record.

Which services require EPA?

EPA is required for services noted in WAC, MAA's billing instructions, and/or fee schedules as needing EPA.

Examples of services requiring EPA:

- **Hysterectomies** (CPT: 51925, 58150-58285, 58545, 58546, 58550, 59525)
Note: CPT codes 58152 and 58267 must meet guidelines for both hysterectomies and bladder repair.

Exceptions: MAA does not require EPA for clients 46 years of age and older; **or** clients that have been diagnosed with cancer(s) of the female reproductive organs (ICD-9-CM: 179-184.9, 198.6, 198.82, 233.1-233.3, 236.0-236.3, and 239.5).
- **Bladder Repairs** (CPT: 51840-51845, 57288-57289, 58152, and 58267)
Note: Bladder repairs are only allowed for clients with a diagnosis of stress urinary incontinence (ICD-9-CM: 625.6, 788.30-788.39)
- **Reduction Mammoplasties** (CPT: 19318)
Note: Reduction Mammoplasties are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.
- **Mastectomies for Gynecomastia** (CPT: 19140)
Note: Mastectomies for Gynecomastia are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.
- **Visual Exams, Dispensing and Fitting Fees, Frames, Glasses, and Lenses**
When in excess of MAA establish limitations.

Physician-Related Services

- **Blepharoplasties** (CPT 67901-67908, 67912) and **Strabismus Surgery** (CPT 67311-67340). Only for clients 18 years of age and older.
- **Physical and Occupational Therapy**
When in excess of MAA establish limitations.
- **Outpatient PET Scans**

Exception: CPT code 78810 and HCPCS codes G0030-G0047 require written/fax prior authorization.

- **Outpatient MRIs and MRAs**
- **Inpatient Medical Admits** (CPT: 99221-99223)
MAA requires EPA for inpatient hospital admissions for the following diagnoses for clients seven years of age and older:

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789-789.09
Back Pain	724-724.6, 724.8-724.9, 846-847.9
Cellulitis	681-681.9, 682, 682.2-682.9
Chronic pancreatitis	577-577.1
Constipation	560.3, 560.39, 564-564.9
Dehydration; Disorders of Electrolyte Imbalance	276-276.6, 276.8-276.9
Headache	784.0
Gastritis/Gastroenteritis	535-535.6, 558-558.9
Migraine Headache	346-346.9
Nausea/vomiting	536.2; 787-787.03
Malaise & Fatigue	780.7-780.79
Painful Respiration	786.52
Related general symptoms	780, 780.4, & 780.9
Respiratory abnormality	786.09

Short stay admissions (less than 24 hours) do not require prior authorization – use CPT codes 99218-99220 for admits, and 99217 for discharge; or 99234-99236 for admission/discharge on the same calendar date.

Clients six years of age and younger do not require prior authorization for inpatient medical admissions. However, these admissions must be medically appropriate in accordance with MAA's established criteria.

**Washington State
Expedited Prior Authorization Criteria Coding List**

Code	Criteria	Code	Criteria
Abdominal Hysterectomy		Vaginal Hysterectomy	
CPT: 58150, 58180, 58200, 58210		CPT: 58270-58285, 58550-58554, 58260-58263, 58290, 58291-58293, 58294, 58545-58546	
101	Diagnosis of <u>abnormal uterine bleeding</u> in a client 30 years of age or older with <u>two or more</u> of the following conditions: <ol style="list-style-type: none"> 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months; 2) Documented hct of <30 or hgb <10; or 3) Documented failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months). 	111	Diagnosis of <u>abnormal uterine bleeding</u> in a client 30 years of age or older with <u>two or more</u> of the following conditions: <ol style="list-style-type: none"> 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months; 2) Documented hct of < 30 or hgb < 10; or 3) Documentation of failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months).
102	Diagnosis of <u>fibroids</u> for any <u>one</u> of the following indications in a client 30 years of age or older: <ol style="list-style-type: none"> 1) Myomata associated with uterus greater than 12 weeks or 10cm in size; 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10; or 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams. 	112	Diagnosis of <u>fibroids</u> for any <u>one</u> of the following indications in a client 30 years of age or older: <ol style="list-style-type: none"> 1) Myomata associated with uterus greater than 12 weeks or 10cm in size; 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct < 30 or hgb < 10; or 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
103	Diagnosis of <u>symptomatic endometriosis</u> in a client 30 years of age or older with the following: <ol style="list-style-type: none"> 1) Significant findings per laproscope; <u>and</u> 2) Unresponsiveness to 3 months of hormone therapy or cauterization. 	113	Diagnosis of <u>symptomatic endometriosis</u> in a client 30 years of age or older with the following: <ol style="list-style-type: none"> 1) Significant findings per laproscope; <u>and</u> 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
104	Diagnosis of <u>chronic advanced pelvic inflammatory disease</u> in a client 30 years of age or older with infection refractory to multiple trials of antibiotics	114	Diagnosis of <u>chronic advanced pelvic inflammatory disease</u> in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

Code	Criteria	Code	Criteria
115	Diagnosis of <u>symptomatic pelvic relaxation</u> (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).	226	<u>Hysterectomy not requiring authorization</u> and <u>Stress Urinary Incontinence</u> meeting criteria 201.
Bladder Neck Suspension CPT: 51840-51845, 57288-57289		Other Hysterectomies and/or Bladder Repairs With Diagnosis of 625.6 or 788.30-788.39 CPT: 51840-51845, 51925, 57288-57289, 58150, 58152, 58180, 58200, 58210, 58240, 58260-58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550-58554, and 59525	
201	Diagnosis of <u>stress urinary incontinence</u> with all of the following: <ol style="list-style-type: none"> 1) Documented urinary leakage severe enough to cause the client to be pad dependent; <u>and</u> 2) Surgically sterile or past child bearing years; <u>and</u> 3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; <u>and</u> 4) Urodynamics showing loss of ureterovesical angle or physical exam showing weak bladder neck; <u>and</u> 5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery. 	230	Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.
Hysterectomy With Colopouretrocystopexy CPT: 51925, 58152, 58267, and 58293		Reduction Mammoplasties/ Mastectomy For Gynecomastia CPT: 19318, 19140	
221	Diagnosis of <u>Abnormal uterine bleeding and Stress Urinary Incontinence</u> -meeting criteria 101 or 111 and 201.	241	Diagnosis for <u>hypertrophy of the breast</u> with: <ol style="list-style-type: none"> 1) Photographs in client's chart, <u>and</u> 2) Documented medical necessity including: <ol style="list-style-type: none"> a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, <u>and</u> b) Conservative treatment not effective; <u>and</u> 3) Abnormally large breasts in relation to body size with shoulder grooves, <u>and</u> 4) Within 20% of ideal body weight, <u>and</u> 5) Verification of minimum removal of 500 grams of tissue from each breast.
222	Diagnosis of <u>Fibroids and Stress Urinary Incontinence</u> -meeting criteria 102 or 112 and 201.	242	Diagnosis for <u>gynecomastia</u> : <ol style="list-style-type: none"> 1) Pictures in clients' chart, <u>and</u> 2) Persistent tenderness and pain, <u>and</u> 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.
223	Diagnosis of <u>Symptomatic Endometriosis and Stress Urinary Incontinence</u> -meeting criteria 103 or 113 and 201.		
224	Diagnosis of <u>Chronic Pelvic Inflammatory Disease and Stress Urinary Incontinence</u> - meeting criteria 104 and 114.		
225	Diagnosis of <u>Symptomatic Pelvic Relaxation and Stress Urinary Incontinence</u> - meeting criteria 115 and 201.		

Physician-Related Services

Code	Criteria	Code	Criteria
Other Reduction Mammoplasties/ Mastectomy For Gynecomastia With Diagnosis Of 611.1 Or 611.9		304 <u>Follow up</u> of <u>brain tumor</u> if done at:	
250	Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.	1) Three months from the date of last MRI/MRA and in the first two years of diagnosis in any of the following cases: a) Tumor is currently being treated; b) Post treatment; c) With documented changes in tumor size; <u>or</u> 2) Six months from the date of last MRI/MRA and in the second to fifth years of diagnosis; <u>or</u> 3) One year from the date of last MRI/MRA in the sixth to tenth year of diagnosis; <u>or</u> 4) Symptoms of recurrence in a client that would be treated aggressively.	
Brain MRI/MRA CPT: 70544-70546, 70551-70559		305 Suspected diagnosis of <u>multiple sclerosis</u> with <u>three or more</u> of the following objective findings:	
301	Suspected diagnosis of <u>acoustic neuroma</u> if one of the following:	1) Progressive weakness or decreased sensation in extremities; 2) Difficulty word finding; 3) Diplopia; 4) Vertigo or vertigo nystagmus; 5) Optic neuritis; 6) Facial weakness; or 7) Positive Lhermitte's sign.	
1) Unilateral sensorineural hearing loss per audiogram; <u>or</u> 2) Decreased discrimination score that is out of proportion to amount of hearing loss per ENT evaluation; <u>or</u> 3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.		Note to 305: Only for initial diagnosis, not as a follow-up.	
302	Suspected diagnosis of <u>pituitary tumor</u> with any <u>two</u> of the following:	306 Suspected diagnosis of <u>toxoplasmosis versus lymphoma versus progressive multifocal leukoencephalopathy</u> in an HIV positive client with:	
1) Galactorrhea; 2) Pre menopausal amenorrhea; 3) Elevated prolactin level (females must have negative pregnancy test); or 4) Positive or inconclusive computed tomography and one of the above with a need for clearer definition		1) Central nervous system changes in a client that would be aggressively treated ; and 2) Positive or inconclusive computed tomography with a need for clearer definition in a client that would be aggressively treated .	
303	Suspected diagnosis of <u>brain tumor</u> with any one of the following:	307 Diagnosis of <u>breast cancer</u> for staging as part of PSCT or BMT protocol.	
1) Unexplained new onset seizure; 2) Objective evidence of increased intracranial pressure; or 3) Positive or inconclusive computed tomography with a need for clearer definition, and <u>one</u> of the above.			

Code	Criteria	Code	Criteria
308	Suspected diagnosis of <u>seizure disorder</u> with unexplained onset of seizures.	5)	Hyperreflexia;
309	Diagnostic evidence of <u>refractory seizures</u> , as part of preoperative work up.	6)	Positive babinski in non-infant; or
310	Suspected diagnosis of <u>residual tumor or residual vascular malformation</u>	7)	Studies showing definitive nerve root compression, and ruling out carpal tunnel syndrome.
Lumbar MRI/MRA		Note to 321: Carpal tunnel syndrome must be ruled out prior to cervical MRI when symptoms indicate possible carpal tunnel syndrome.	
CPT: 72148, 72149, 72158		322	Suspected diagnosis of <u>tumor or abscess</u> with a bone scan or x-ray suspicious for same.
311	Suspected diagnosis of <u>Herniated Nucleus Pulposus or Tumor</u> in a surgical candidate with <u>two</u> or more of the following objective findings:	Thoracic MRI/MRA	
	1) New onset of bowel or bladder incontinence not related to known diagnosis;	CPT: 72146, 72147, 72157	
	2) Asymetric or bilaterally absent tendon reflexes in the lower extremity (patella/achilles);	331	Suspected diagnosis of <u>tumor or abscess</u> :
	3) Visible atrophy of key muscle groups of lower extremities;	1)	With a bone scan or x-ray suspicious for same, <u>or</u>
	4) Decreased sensation in a dermatomal pattern not previously attributed to another diagnosis;	2)	Evidence of myelopathy, such as hyperreflexia, positive babinski in a non-infant, ataxia, etc.
	5) Significant weakness of key muscle groups of either or both lower extremity; or	Pelvic MRI/MRA	
	6) Positive study indicating definitive nerve root compression.	CPT: 72195-72197	
312	Suspected diagnosis of <u>tumor or abscess</u> with a bone scan or x-ray suspicious for same.	341	Suspected diagnosis of <u>avascular necrosis</u> with:
Cervical MRI/MRA		1)	Pain in the hip radiating to the knee; <u>and</u>
CPT: 72141, 72142, 72156		2)	A history of one of the following:
321	Suspected <u>herniated nucleus pulposa or tumor</u> with <u>two or more</u> of the following objective findings:	a)	Previous trauma;
	1) Decreased tricep, bicep, or brachial radialis reflex;	b)	Intracapsular fractures;
	2) Decreased sensation in upper extremities in a dermatomal distribution;	c)	Alcoholism;
	3) Decreased muscle strength of upper extremities and limitation of movement;	d)	High dose steroid use;
	4) Upper extremity muscle atrophy;	e)	Air embolism from diving, or
		f)	Hemoglobinopathies
		342	Suspected diagnosis of <u>tumor or abscess</u> with a bone scan or x-ray suspicious for same.

Code	Criteria	Code	Criteria
Knee MRI/MRA CPT: 73721-73723		Upper Extremity MRI/MRA CPT: 73218-73223	
351	Suspected <u>anterior cruciate ligament tear</u> when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <u>three</u> of the following: <ol style="list-style-type: none"> 1) History of hyperextension injury with immediate swelling, and complaints of giving way or buckling; <u>or</u> 2) Four or more weeks of conservative care; <u>or</u> 3) Current exam with the following findings: hemarthrosis and/or positive Lockman's and/or positive pivot shift; <u>or</u> 4) MRI is necessary to choose treatment option(s). 	361	Suspected diagnosis of <u>tumor or abscess</u> with a bone scan or x-ray suspicious for same.
352		Lower Extremity MRI/MRA CPT: 73718-73723	
Suspected <u>posterior cruciate ligament tear</u> when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <u>two</u> of the following: <ol style="list-style-type: none"> 1) History of direct blow to anterior tibia or forced hyperflexion; <u>or</u> 2) Four or more weeks of conservative care; <u>or</u> 3) Current clinical with <u>one or more</u> positive findings: positive drawers, test positive tibial sag. 		371	
353		Abdominal MRI/MRA CPT: 74181-74183	
Suspected <u>meniscal tear</u> when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <u>two</u> of the following: <ol style="list-style-type: none"> 1) History of twisting injury with subsequent catching, locking, and swelling; <u>or</u> 2) Four or more weeks of conservative care; <u>or</u> 3) <u>One or more</u> of the following exam findings: joint line tenderness, positive McMurrays. 		381	
		Other MRI/MRA All other covered MRI/MRA	
		390	
		MRIs/MRAs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.	
		Note: If billing for more than one MRI/MRA <u>for the same reason</u> , use criteria code 390.	
		Note: If billing for more than one MRI/MRA <u>for different reasons</u> , build two separate expedited prior authorization numbers.	

Code	Criteria	Code	Criteria
PET Scan HCPCS code: G0125 DX: 235.7, 793.1		PET Scans HCPCS codes: G0212, G0215, G0218, G0222 DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 190.9, 200.00-202.28	
382	PET imaging regional or whole body when the client has a pulmonary nodule.	385	PET Imaging whole body for re-staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma after completion of treatment for one of the following reasons: <ol style="list-style-type: none"> 1) To detect residual disease; or 2) To detect suspected recurrence; or 3) To determine the extent of known recurrence.
PET Scans HCPCS codes: G0210, G0213, G0216, G0220		PET Scans HCPCS codes: G0223, G0226	
383	PET Imaging whole body to diagnose; lung cancer (non small cell), colorectal cancer, melanoma, or lymphoma when at least one of the following is true: <ol style="list-style-type: none"> 1) The PET results may assist in avoiding an invasive diagnostic procedure; or 2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. 	386	PET Imaging whole body or regional to diagnose; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when at least one of the following is true: <ol style="list-style-type: none"> 1) The PET results may assist in avoiding an invasive diagnostic procedure; or 2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.
PET Scans HCPCS codes: G0211, G0214, G0217, G0221 DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 190.9, 200.00-202.28		PET Scans HCPCS codes: G0224, G0227 DX: 160-161.9, 170, 170.1, 171.0	
384	PET Imaging whole body for initial staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma when one of the following is true: <ol style="list-style-type: none"> 1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or 2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and 3) The clinical management of the client would differ depending on the stage of the cancer identified. 	387	PET Imaging whole body or regional for initial staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when at least one of the following is true: <ol style="list-style-type: none"> 1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or 2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and

Code	Criteria	Code	Criteria
	3) The clinical management of the client would differ depending on the stage of the cancer identified.		
PET Scans		PET Scans	
HCPCS codes: G0225, G0228		HCPCS codes: G0234	
DX: 160-161.9, 170, 170.1, 171.0		DX: 162.0-162.9	
388	PET Imaging whole body or regional for re-staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer after the completion of treatment for one of the following:	393	PET regional or whole body, gamma camera only, when the study is for one of the following:
	1) To detect residual disease;		1) A solitary pulmonary nodule following CT; or
	2) To detect suspected recurrence; or		2) Initial staging of pathologically diagnosed non-small cell lung cancer.
	3) To determine the extent of known recurrence.		
PET Scans		PET Scans	
HCPCS codes: G0229		HCPCS codes: G0253, G0254	
DX: 345.11, 345.41, 345.54		DX: 174.0, 175.9	
389	PET Imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures.	394	PET imaging, for breast cancer, full and partial ring, when the study is for <u>one</u> of the following:
			1) Staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after, or prior to, course of treatment; or
			2) Evaluation of response to treatment, performed during course of treatment.
PET Scans		PET Scans	
HCPCS codes: G0230		HCPCS codes: G0296	
DX: 410.00-414.9		DX: 193	
391	PET Imaging; metabolic assessment for myocardial viability when a SPECT study is inconclusive.	395	PET imaging, full and partial ring, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.
PET Scans			
HCPCS codes: G0231, G0232, G0233			
DX: 153.0-154.8, 200.00-202.28, 202.80-202.88, 172.0-172.9			
392	PET WhBD, gamma cameras only, for one of the following reasons:		
	1) Recurrence of colorectal or colorectal metastatic cancer;		
	2) Recurrence of melanoma or metastatic melanoma; or		
	3) Staging and characterization of lymphoma.		



Physician-Related Services



Code	Criteria	Code	Criteria
Medical Admits CPT: 99221-99223			
401	Diagnosis of <u>Cellulitis</u> (681-681.9, 682, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any <u>one</u> of the following: 1) Incision & drainage during admit; <u>or</u> 2) White Count greater than 10 on admit; <u>or</u> 3) Persistence or progression of fever, lymphadenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.	406	Diagnosis of <u>headaches</u> (784.0, 346-346.9) in a client receiving intravenous DHE, during the hospital stay, for greater than 30 hours.
402	Diagnosis of <u>Abdominal Pain</u> (789-789.09) in a client with a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours.	407	Diagnosis of <u>chronic pancreatitis</u> (577, 577.1) in a client: 1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; <u>or</u> 2) That is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.
403	Diagnosis of <u>Dehydration or Electrolyte Imbalances</u> (276-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.	408	Diagnosis of <u>back pain</u> (724-724.5, 724.8-724.9, 846-847.9) in a client: 1) Failed outpatient treatment; <u>and</u> 2) Continued use of intravenous pain medication, during the hospital stay, greater than 30 hours; <u>or</u> 3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.
404	Diagnosis of <u>Nausea/Vomiting</u> (536.2; 787-787.03) in a client: 1) With a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours; <u>or</u> 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.	409	Diagnosis of <u>constipation</u> (560.3, 560.39, 564-564.9) in a client: 1) Failed outpatient treatment; <u>or</u> 2) Recent abdominal surgery; <u>and</u> 3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.
405	Diagnosis of <u>Gastritis</u> (535-535.6, 558-558.9) in a client: 1) With a Nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; <u>or</u> 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.	Other Inpatient Medical Admits	
		420	Inpatient medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria, for continued stay over 24 hours. Medical appropriateness must be clearly evident by the documentation in the client's medical record.

Code	Criteria	Code	Criteria
Visual Exams CPT: 92014-92015			
610	Eye Exam within two (2) years of last exam when no medical indication exists and both of the following are documented in the client's record: 1) Glasses or contacts are broken or lost; and 2) Last exam was 18 months ago or longer.	619	Durable Frames (American Athletic or Invincible) when one of the following is documented in the client's record: 1) Client has a seizure disorder that results in frequent falls; or 2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.
628	Diopter change of +/- one.	620	Flexible Frame (Daryl or Scott) when one of the following is documented in the client's record: 1) Client has a seizure disorder that results in frequent falls; or 2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.
Dispensing/Fitting Fees For Glasses CPT: 92340-92342			
615	Glasses (both frames and lenses) within two (2) years of last dispense may be replaced when glasses are broken or lost and all of the following are documented in the client's record: 1) Copy of current prescription (must not be older than 17 months); and 2) Date of last dispense; and 3) Both frames and lenses are broken or lost.	Dispensing/Fitting Fees For Lenses Only CPT: 92341, 94342	
Dispensing/Fitting Fees For Frames Only CPT: 92340		623	Lenses Only within two (2) years of last dispense when the lenses only are lost or broken and all of the following are documented in the client's record: 1) Copy of current prescription (prescription must not be older than 17 months); and 2) Date of last dispense; and 3) Documentation of lens damage or loss.
618	Frames Only within two (2) years of last dispense may be replaced when frames only are broken, and all of the following are documented in the client's record: 1) No longer covered under the manufacturer's one (1) year warranty; and 2) Copy of current prescription demonstrating the need for prescription eye wear; and 3) Documentation of frame damage.	624	Lenses Only within two (2) years of last dispense, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lenses at no charge) when all of the following are documented in the client's record: 1) Copy of current prescription (prescription must not be older than 17 months); and 2) Date of last dispense; and 3) The current exam shows a refractive change of .75 diopters or more; and

Physician-Related Services

Code	Criteria	Code	Criteria
	<p>4) The client has headaches, blurred vision, difficulty with school or work and it has been diagnosed by a physician as caused from the inability to see adequately; and</p> <p>5) The client does not have a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy).</p> <p>Note: In conditions other than pregnancy, if vision has been stable for 3 months and medical condition is stable, lenses are allowed when (1)-(4) previously listed are true.</p> <p>625 <u>High Index Lenses</u> when one of the following is documented in the client's record:</p> <p>1) Spherical correction is greater than, or equal to, +/- 8 diopters; or</p> <p>2) Cylinder correction is greater than, or equal, to +/- 3 diopters.</p> <p>626 <u>Executive bifocals and trifocals</u> for clients 11 years of age and older, with a diagnosis of accommodative esotropia or strabismus documented in the client's record.</p> <p>628 Diopter change of +/- one.</p>		
	<p>Dispensing/Fitting Fees For Contacts CPT: 92070, 92310-92313</p> <p>627 <u>Contacts (client must meet criteria found in MAA's Vision Care Billing Instructions for contacts)</u> within one (1) year of last dispense may be replaced when contacts are broken or lost and both of the following are documented in the client's record:</p> <p>1) Copy of current prescription (must not be older than 17 months) and</p> <p>2) Date of last dispense documented.</p> <p>628 Diopter change of +/- one.</p>		<p>Blepharoplasties CPT: 67901-67908</p> <p>630 Blepharoplasty for noncosmetic reasons when <u>both</u> of the following are true:</p> <p>1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and</p> <p>2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.</p> <p>Strabismus Surgery CPT: 67311-67340</p> <p>631 Strabismus surgery for clients 18 years of age and older when <u>both</u> of the following are true:</p> <p>1) The client has double vision; and</p> <p>2) It is not done for cosmetic reasons.</p> <p>Physical Therapy CPT: 97010-97150, 97520-97537, 97750</p> <p>640 <u>An additional 48 Physical Therapy program units</u> when the client has already used the allowed program units for the current year and has one of the following surgeries or injuries:</p> <p>1) Lower Extremity Joint Surgery;</p> <p>2) CVA not requiring acute inpatient rehabilitation; or</p> <p>3) Spine surgery.</p> <p>641 <u>An additional 96 Physical Therapy program units</u> when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.</p>

Code	Criteria	Code	Criteria
Occupational Therapy CPT: 97110, 97112, 97520, 97530, 97532, 97533, 97535, 97537		3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained. HCPCS: L3030	
644	<u>An additional 12 Occupational Therapy</u> visits when the client has used the allowed visits for the current year and has <u>one</u> of the following: <ol style="list-style-type: none"> 1) Hand\Upper Extremity Joint Surgery; or 2) CVA not requiring acute inpatient rehabilitation. 	780	Foot insert, removable, formed to patient foot. One (1) pair allowed in a 12-month period if one of the following criteria is met: <ol style="list-style-type: none"> 1) Severe arthritis with pain; 2) Flat feet or pes planus with pain; 3) Valgus or varus deformity with pain; 4) Plantar facitis with pain; or 5) Pronation.
645	<u>An additional 24 Occupational Therapy</u> visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.	<div>  NOTE: <ol style="list-style-type: none"> 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 1-800-292-8064. 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria. </div>	
Orthotics HCPCS: L3000		HCPCS: L3310 & L3320	
784	Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met: <ol style="list-style-type: none"> 1) Required to prevent or correct pronation; 2) Required to promote proper foot alignment due to pronation; or 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc. 	781	Lift, elevation, heel & sole, per inch. Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.
<div>  Note: <ol style="list-style-type: none"> 1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 1-800-292-8064. 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria. </div>		HCPCS: L3334	
		782	Lift, elevation, heel, per inch Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

Code	Criteria	Code	Criteria
<div> NOTE:</div> <div><div>1) Lifts are not covered for less than one (1) inch.</div><div>2) Lifts are only allowed on one (1) pair of client shoes.</div><div>3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 1-800-292-8064.</div><div>4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.</div></div>			
HCPCS: L3215 or L3219			
785	Orthopedic footwear, woman's or man's shoes, oxford.		
Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:			
<div><div>1) When one or both shoes are attached to a brace;</div><div>2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts;</div><div>3) To accommodate a partial foot prosthesis; or</div><div>4) To accommodate clubfoot.</div></div>			
<div> NOTE:</div> <div><div>1) MAA does not allow orthopedic footwear for the following reasons:</div><div><div>a) To accommodate L3030 orthotics;</div><div>b) Bunions;</div><div>c) Hammer toes;</div><div>d) Size difference (mismatched shoes); or</div><div>e) Abnormal sized foot.</div></div></div>			

MAA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650 and WAC 388-531-0700]

The following services must be performed in an MAA-approved Center of Excellence (COE) and **do not require prior authorization**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants;
- Inpatient Chronic Pain Management; and
- Sleep studies (CPT codes 95805, 95807-95811), only allowed for ICD-9-CM diagnoses 780.51, 780.53, 780.57, or 347.



Note: When billing on a paper HCFA-1500 claim form, note the COE in field 32. When billing electronically, note the COE in the *Comments* section.

MAA-Approved Organ Transplant Centers of Excellence (COE)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Medical Center/Seattle	<ul style="list-style-type: none"> • Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242 • 33945 • 47135-47136 • 50360, 50365, 50380
Dorenbacher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
Fred Hutchinson Cancer Research Center/Seattle	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
Good Samaritan Hospital Medical/Puyallup	<ul style="list-style-type: none"> • PSC-T 	<ul style="list-style-type: none"> • 38205-38206, 38240-38242
Inland NW Blood Center	<ul style="list-style-type: none"> • PSC-T 	<ul style="list-style-type: none"> • 38205-38206, 38240-38242
Legacy Good Samaritan Hospital/Portland (Northwest Marrow Transplant Program)	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
Mary Bridge Children's Hospital/Seattle	<ul style="list-style-type: none"> • PSC-T (autologous only) 	<ul style="list-style-type: none"> • 38206, 38242
Oregon Health Sciences University (OHSU)/Portland	<ul style="list-style-type: none"> • Heart • Liver • Kidney • Pancreas 	<ul style="list-style-type: none"> • 33945 • 47135-47136 • 50360, 50365, 50380 • 48160, 48554
Providence St. Peter Hospital/Olympia	<ul style="list-style-type: none"> • PSC-T 	<ul style="list-style-type: none"> • 38206, 38240-38242
Sacred Heart Medical Center/Spokane	<ul style="list-style-type: none"> • Kidney • Heart • Heart/Lung(s) • Lung 	<ul style="list-style-type: none"> • 50360, 50365, 50380 • 33945 • 33935 • 32851-32854
Seattle Cancer Care Alliance/Seattle	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
St. Joseph's Hospital/Tacoma	<ul style="list-style-type: none"> • BMT (autologous only) • PSC-T 	<ul style="list-style-type: none"> • 38230, 38242 • 38205-38206, 38240-38242

MAA-Approved Organ Transplant Centers of Excellence (COE) (Cont.)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	<ul style="list-style-type: none"> • Kidney • PSC-T 	<ul style="list-style-type: none"> • 50360, 50365, 50380 • 38231, 38240-38241
University of Washington Medical Center/Seattle	<ul style="list-style-type: none"> • BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas 	<ul style="list-style-type: none"> • 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 33935 • 32851-32854 • 50360, 50365, 50380 • 47135-47136 • 48160, 48554
Virginia Mason Hospital/Seattle	<ul style="list-style-type: none"> • Kidney • Pancreas • BMT • PSC-T 	<ul style="list-style-type: none"> • 50360, 50365, 50380 • 48160, 48554 • 38230, 38240-38241 • 38231, 38240-38241

MAA-Approved Sleep Centers

[Refer to WAC 388-531-1500]

MAA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Diagnostic Sleep Disorder Program Center	Children's Hospital and Medical - Seattle, WA
Eastside Sleep Disorder Clinic	Overlake Hospital Medical Center - Bellevue, WA
Highline Sleep Disorders Center	Highline Community Hospital - Seattle, WA
Holy Family Sleep Disorder Center	Holy Family Hospital -Spokane, WA
Kathryn Severyns Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
Multi Care Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital - Tacoma, WA
Providence Everett Sleep Disorder Center	Providence Everett Medical Center - Everett, WA.
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorders Center Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center of Harrison Hospital	Harrison Hospital - Bremerton, WA
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Related Breathing Disorders Laboratory St Clare Hospital	St. Clare Hospital - Tacoma, WA
Sleep Studies Laboratory Mid Columbia Medical Center	Mid Columbia Medical Center - Dalles, OR
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5 th Suite 400 W - Spokane, WA
Harborview Medical Center	Harborview Medical Center - Seattle, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA

Website Update Only

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Providers must:

- Use CPT codes 95805, 95807-95811 for sleep study services.
- Enter the location of the approved sleep center where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of MAA-approved sleep center.) Enter the information into the *Comments* section of the claim form.



Note: All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57**, or Narcolepsy **347**.

MAA-Approved Inpatient Pain Clinics

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma